State of Illinois
Department of Human Services

# AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

**Use this form if you want someone to act on your behalf with the Department of Human Services for purposes of appealing: the inaction of the Department; or a decision made by the Department.**

**INSTRUCTIONS FOR COMPLETING THIS FORM:**

- Appoint an Authorized Representative for Appeals: Complete Section A (the Appellant/Client Information section) and complete, sign, and date Section B (the Appellant/Client Permission section). Have your Representative complete, sign and date Section C (the Representative section).
  - You can only name one person or organization as your Authorized Representative.
  - If Section A is signed by the Appellant/Client's power of attorney or legal guardian per a court order, you must send that legal document with this form.
  - An Authorized Representative for Appeals may be any person or organization you choose, regardless of whether you pay them. To apply for free legal help:
    - In Cook County (including the City of Chicago) - Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
    - In other counties in Northern or Central Illinois with area codes (309), (815) or (847) - Prairie State Legal Services: (800) 531-7057
    - In other counties in Central or Southern Illinois where the area code is (217) or (618) - Land of Lincoln Legal Assistance Foundation: (877) 342-7891.

- Right to End Representation: You may stop this person or organization from acting as your Authorized Representative for Appeals at any time. If you decide you no longer want this person or organization to act on your behalf, complete Section A (the Appellant/Client Information section) and complete, sign, and date Section D (the End My Authorized Representative for Appeals section). This change will take effect once the Bureau of Hearings receives the signed request from you.

• **Keep a copy of this form for your records**.

**HOW TO SUBMIT THIS FORM -** Use one of the 2 easy ways below:

1. You can assign an Authorized Representative for Appeals online, using the ABE Appeals Portal. Go to: https://abe.illinois.gov/abe/access/appeals and follow the prompts when filing an appeal or updating your account, and then upload this completed form into ABE; or

2. Fill out, sign, and send this form by email, fax, mail, or deliver in person to:
   a. Email: DHS.BAH@illinois.gov
   b. Mail: DHS Bureau of Hearings
   69 W. Washington, 4th Floor
   Chicago, IL 60602
   c. Fax: 312 793-3387
   d. In Person at the mailing address above; or at your local FCRC.

- Requests to End My Authorized Representative for Appeals made on this form may be returned as indicated above.
- If you have questions about this form, you may contact the Bureau of Hearings via the methods listed above or by calling: 1-800-435-0774.

THIS PAGE INTENTIONALLY LEFT BLANK

State of Illinois
Department of Human Services

# AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

## SECTION A

**APPELLANT/CLIENT INFORMATION**: Complete this section if you are the Appellant/Client (If, signed by the Client's power of attorney or legal guardian per a court order, then you **must** submit that legal document with this form or it will not be accepted).

Appellant/Client Name: _____ Date of Birth _____

Social Security Number: _____ Individual I.D. Number (if known): _____

Name of Authorized Representative for Appeals, named in Section C, below: _____

Relationship of Representative for Appeals to Appellant/Client: _____

I want to (check only one box):

☐ Appoint a new Authorized Representative for Appeals, pursuant to 89 Ill. Adm. Code 14.21;

☐ Change the powers my Authorized Representative for Appeals has; or

☐ End my Authorized Representative's authorization for Appeals (skip Sections B and C and go to Section D (End My Authorized Representative for Appeals) on Page 3).

## SECTION B

**APPELLANT/CLIENT PERMISSION:** Complete, sign, and date this section if you are the Appellant/Client.

| Item | Things I want my Authorized Representative for Appeals to do for me | Check the boxes that apply |
|---|---|---|
| Appeals | • Act on my behalf for Appeals. Representation will continue in the event that I die before the appeal is complete | ☐ |
| Survive Death | In the event that I die before a Final Administrative Decision is implemented, I **do not** authorize this representative to continue with the appeal after my death. | ☐ (check if you **do not** want representation to survive death) |

By signing below, I give permission to the Authorized Representative for Appeals, named in Section C of this form, to act on my behalf for the items I have checked in Section B of this form, pursuant to 89 Ill. Adm. Code 14.21. I understand that the action or inaction of an authorized representative shall be deemed to be the action or inaction of myself. I also understand that I am responsible for the information my Authorized Representative for Appeals gives the Department, including any information that may be incorrect. Finally, I understand that I must complete a request to end any Authorized Representative for Appeals that I no longer want to act on my behalf.

Appellant/Client Signature: _____ Date: _____

State of Illinois
Department of Human Services

# AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

## SECTION C

**REPRESENTATIVE SECTION:** Complete, sign, and date this section if you are the Representative.

Check only one box:

☐ I am an individual representing the Appellant/Client. Complete 1, 2, 3, 4 and 5a.

☐ I am with an organization representing the Appellant/Client. Complete 1, 2, 3, 4 and 5b.

**1.** Representative Name: _____

**2**. Representative Address: _____

_____

**3.** Representative Telephone Number: _____

**4**. Representative Email Address: _____

**5a.**

I agree to keep the confidentiality of any information regarding the Appellant/Client provided to me, in my capacity as Authorized Representative for Appeals. I understand that I am expected to be knowledgeable of the Appellant's/Client's circumstances.

Signature of Representative: _____ Date: _____

**5b.**

Name of Individual completing this section and signing below: _____

Name of Organization: _____

I agree that I have authority to represent the Organization listed above. I also agree, on behalf of the Organization, that such organization will maintain the confidentiality of any information regarding the Appellant or client. The Organization and all providers, staff members, and volunteers of the Organization will adhere to all applicable State and Federal laws concerning conflicts of interest, confidentiality of information, and prohibitions against reassignment of provider claims.

Signature on behalf of Organization Representative: _____ Date: _____

## SECTION D

**END MY AUTHORIZED REPRESENTATIVE FOR APPEALS SECTION**

Instructions to the Appellant/Client:

- You should complete this section ***only if*** you no longer want your Authorized or Organization Representative to act on your behalf for appeals.
- Complete, sign, and date below and submit this form according to the instructions on page 1.

• **You must also complete Section A on page 2.**

I no longer want the person or organization named below to act as my Authorized Representative for Appeals.

Signature: _____ Date: _____